

# Medicare DMEPOS Competitive Bidding Demonstration

## Bidding Forms for San Antonio, TX

### IMPORTANT!

- (1) Read your Request for Bids and all instructions before attempting to complete any form.
- (2) Incomplete, or incorrectly completed, forms will be returned to the bidder.
- (3) Responses should be typed or printed legibly in blue or black ink.
- (4) Instructions for opening the bidding software are included in this booklet.



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Form A: Application for Suppliers

Form B: Bidding Sheet for Hospital Beds & Accessories

Form B: Bidding Sheet for Oxygen Contents, Equipment & Supplies

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Form B: Bidding Sheet for Non-Customized Orthotic Devices

Form B: Bidding Sheet for Nebulizer Inhalation Drugs

Form C: On-Site Inspection Checklist **(for HCFA use only)**

Forms D & E Cover Letter

Form D: Bank Reference

Form E: Referral Source Reference

Form F: Financial Data **(for bidders in the competitive range only)**

Form G Cover Letter

Form G: Suppliers for Nursing Homes **(for nursing home use only)**

Form H: Monitoring Form **(for HCFA use only)**

## Bidding Forms Instructions

Each bidder may complete its bid using either the pre-printed forms or the bidding software provided on disk. In either case, a bidder must send the signed, original bidding forms and two photocopies of the signed, original bidding forms in order for its bid to be evaluated. Bidders may photocopy blank pre-printed forms if they require additional copies.

Bidders may find they require additional space to complete their answers. If this is the case, additional pages may be attached to the bidding forms. Mark any additional pages with the appropriate form letter and item number to avoid confusion. Please do not attach samples unless specifically requested. When requested, samples should be limited to select pages of a manual or document rather than the manual or document in its entirety.

All bids must be received — not postmarked — before the date specified in the timetable accompanying your Request for Bids (RFB). Bids received after this deadline will be disregarded. Suppliers or networks may send their bids to either of the following addresses.

### **U.S. Mail**

AG-400  
Medicare DMEPOS  
Competitive Bidding Demonstration  
PO Box 100164  
Columbia, SC 29202-3164

### **Overnight Delivery Service**

AG-400  
Leslie Epperly, Project Manager  
Medicare DMEPOS  
Competitive Bidding Demonstration  
17 Technology Circle  
Columbia, SC 29203  
(888) 289-0710

## **Forms**

Bidders must complete their bids using the following forms: (1) Form A: Application for Suppliers, (2) Form B: Bidding Sheet, (3) Form D: Bank Reference, (4) Form E: Referral Source Reference and (5) Form F: Financial Data. The information requested on these forms will be reviewed only in relation to the product category (or categories) on which the supplier or network is bidding and the service areas that the bidder wishes to serve.

- (1) **Form A** requests general information about a supplier, as well as billing and financial information. If a network is bidding, each member supplier must complete Form A separately from every other member supplier.

- (2) **Form B** is the bidding sheet. There is one for each of the five product categories. Bidders should record their bid prices for designated products and other product-category specific information on Form B. If a network is bidding, its members should compile a single bid; only one bid per product category will be accepted from a network.
- (3) ***All suppliers are responsible for ensuring at least one bank or other financial institution with which they do business complete Form D. Completed Forms D must be sent directly to Palmetto GBA by the bank references. All Forms D must be received before the date specified in the timetable accompanying your RFB.*** A cover letter and self-addressed envelopes are enclosed. Palmetto GBA will expect to receive bank references from those names listed in Item (9) of each supplier's Form A by the bid submission deadline. All references are required for a supplier or network's bid to be complete. Certified mail or any other service that tracks delivery is recommended. Suppliers may choose to assume the cost for the method of delivery they prefer.

Form D is a questionnaire for the bidder's bank references. It is intended to confirm that the bidder is financially sound and able to serve expanding business. If a network is bidding, each member supplier must solicit bank references separately from every other member supplier.

- (4) ***All suppliers are responsible for ensuring at least five referral sources each complete Form E. Completed Forms E must be sent directly to Palmetto GBA by the referral sources. All Forms E must be received before the date specified in the timetable accompanying your RFB.*** A cover letter and self-addressed envelopes are enclosed. Palmetto GBA will expect to receive referral source references from those names listed in Item (7) of Form A by the bid submission deadline. All references are required for a supplier or network's bid to be complete. Certified mail or any other service that tracks delivery is recommended. Suppliers may choose to assume the cost for the method of delivery they prefer.

Form E is a questionnaire for the bidder's referral source references. Referral sources are those professionals or organizations that refer patients to the supplier for service. It is intended to confirm that the supplier provides a high level of quality and service in the demonstration site, ensuring customer satisfaction. If a network is bidding, each member supplier must solicit referral source references separately from every other member supplier.

- (5) ***Form F is not required unless the supplier or network is in the competitive range.*** Suppliers will be notified if they are in the competitive range and given 10 business days after it is requested to complete and submit the form. Bidders may provide this information in advance of the request, however, if they prefer.

Form F requests evidence of a supplier's ability to remain in business throughout the demonstration. Suppliers must be financially sound in order to provide the quality and range of items that will be required during the demonstration. If a network is bidding, each member supplier must complete Form F separately from every other member supplier.

The remaining forms will be used by Palmetto GBA to record information gathered during a supplier's on-site inspection, to request information from nursing homes in the demonstration site, and to monitor Demonstration Suppliers once the demonstration has begun.

- (1) Inspectors who visit the facilities of suppliers in the competitive range will use **Form C: On-Site Inspection** as a checklist and mechanism for documenting their findings. Inspectors are asked to provide notes explaining their answers, when the inspectors deem such notes appropriate. Suppliers are not required to have every item that appears on the checklist. On-site inspectors will be looking for evidence that the supplier provides a high level of quality and service. Inspectors will typically make appointments with the suppliers prior to their on-site inspection.
- (2) Once Demonstration Suppliers have been selected, nursing homes in the demonstration site will be asked to complete **Form G: Suppliers for Nursing Homes**. It is intended to identify those Non-Demonstration Suppliers from which nursing homes will continue to purchase designated products during the demonstration.
- (3) The local ombudsman will use **Form H: Monitoring Form** to observe and record Demonstration Suppliers' level of quality and service during the demonstration. The ombudsman will visit suppliers annually or if a complaint raises concern over whether the supplier is fulfilling the requirements and standards essential to its demonstration status. Depending on the product category (or categories) for which they were selected, Demonstration Suppliers are not required to have every item that appears on the form. The ombudsman will typically make appointments with a supplier prior to visiting.

## **Bidding**

Each bidder must bid on at least one product category but is not required to bid on every product category. A bidder must submit a bid price for each HCPCS code within the product category (or categories) on which it is bidding. If even one bid price is missing from Form B, the bid will not be considered. Once bids are received, they are considered final and irrevocable. Bidders will not be allowed to revise or amend their bid prices. Each product category will be evaluated as a separate bid.

HCPCS codes not listed on Form B but which fall within one of the product categories are included in the demonstration. (See "Appendix F.") Therefore, they must be provided by

Demonstration Suppliers for that product category. Such items may be reimbursed using Medicare's current, statewide fee schedule or reasonable-charge policy. This provision includes new HCPCS codes effective when suppliers bid, HCPCS codes assigned after the demonstration begins and HCPCS codes representing miscellaneous or individually considered items.

## **Networks**

Only one bidding sheet per product category will be accepted from a supplier with multiple outlets. In addition, only one bid per product category will be accepted from a network. Network member suppliers will not be allowed to bid separately from their network. Nor will member suppliers be allowed to join more than one network.

## **Confidentiality**

Bidders should mark or stamp their Forms F and any financial documentation with the words **"Proprietary and Confidential."** Confidentiality of all information provided when a bidder submits its bid will be maintained. However, an independent evaluator will be granted access to bidders' proposals. The evaluator will report regarding this information in only an anonymous or aggregate format.

Also, proposed levels of quality and service may be shared during the general debriefing which will follow HCFA's selection of Demonstration Suppliers for the demonstration. Again, the information will be presented in only an anonymous or aggregate format. Finally, bidding information may be reviewed for evaluation purposes by the General Accounting Office (GAO). HCFA will request that the GAO report bidding information in only an anonymous or aggregate format.

All HCFA and contractor staff with access to bid information will be required (1) to sign a statement agreeing to maintain bidders' confidentiality and (2) to declare any conflicts of interest. In addition, information provided by bidders not selected for the demonstration will be destroyed in a secure manner such as shredding or incineration once it is no longer required for the demonstration. Confidential commercial and financial information of those bidders selected for the demonstration will also be destroyed in a secure manner.

## **Questions**

Bidders should call (888) 289-0710 toll-free if they require clarification of these instructions.

## **Software**

The bidding software allows users to complete and print original bidding forms. Microsoft Windows '95/'98/NT is the preferred operating system.

Bidders who use the bidding software are asked to save their bids to the enclosed disk, labeled "Medicare DMEPOS Competitive Bidding Software," and send this disk along with the signed, original bidding forms and the two photocopies.

- (1) Select START then RUN from the taskbar.
- (2) Type "A:\CompetitiveBid.exe".
- (3) Select the "OK" button.
- (4) Click on the "Continue" button.
- (5) Select the "Agree" button.
- (6) Select the "OK" or "Yes" button.
- (7) "Software Instructions.txt" file will appear. This file is the instructions for using the bidding software. You can print the instructions or read them on screen. Close window.
- (8) Double click on the "HCFA Forms for Competitive Bidding Demonstration" icon.
- (9) Main Menu should appear.

Macintosh users will need to complete the supplier or network's bid manually.

Medicare DMEPOS  
Competitive Bidding Demonstration  
Form A: Application for Suppliers

For HCFA Use Only

Supplier Application No.

Date Application Received

Please read the instructions completely. Incomplete, or incorrectly completed, forms will be returned to the supplier.

San Antonio, Texas

Metropolitan Area (MA)

**Supplier's Legal Name**

Indicate the legal name of the supplier completing this form. A supplier's legal name is the official entity name under which it is authorized to do business. This name should be the one used when reporting to the IRS and to Medicare.

**NSC Identification No.**

This 10-digit number is required to bill Medicare for DMEPOS.

**(1) Network Information**

(A) Is this application submitted by a network member supplier?

☐ Yes ☐ No

A network is a formal association or partnership between suppliers. Each member of a network must complete Form A separately from every other member of the network. All other members of a supplier network must be identified in Item (1D).

(B) If (1A) is "Yes," enter the primary supplier's NSC Identification No.

If the supplier is a network member, indicate the NSC Identification No. of the primary supplier in the network. The primary supplier will bill Medicare and receive reimbursement on behalf of all the network's members.

(C) If (1A) is "Yes," enter the primary supplier's legal name.

(D) If (1A) is "Yes," list the network's other supplier members.

Member Supplier's Legal Name

NSC Identification No.

1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(2) Supplier's Identifying Information****(A) Employer Identification No.** \_\_\_\_\_

Indicate the federal employer identification number of the supplier completing this form.

**(C) Electronic Submitter No.** \_\_\_\_\_

Indicate the electronic submitter number, as issued by the DMERC's EDI department. If the supplier is a network member, enter the primary supplier's electronic submitter number. All demonstration claims must be submitted electronically.

State (US) \_\_\_\_\_ Date (MONTH-YYYY) \_\_\_\_\_

**(D) Established/Incorporated** \_\_\_\_\_

Enter the two-letter abbreviation for the state in which the supplier completing this form was established or incorporated. Also provide the date established or incorporated.

**(E) Contact Person(s)** Indicate the names of the individual(s) who should be contacted to answer questions regarding the supplier's bid.

First	Last
_____	_____
First	Last
_____	_____

(U.S. POSTAL SERVICE ABBREVIATIONS ONLY)

City

State (US)

ZIP (00000)

**(F) Mailing Address** \_\_\_\_\_

(INCLUDE AREA CODE.)

(INCLUDE AREA CODE.)

**(G) Telephone No.** \_\_\_\_\_**(H) Fax No.** \_\_\_\_\_**(3) Supplier's Business Information****(A) In This MA, Doing Business As**

Indicate all names under which the supplier completing this form is doing business in the MA.

1	_____
2	_____
3	_____

**(B) Length of Time Doing Business**

Indicate the length of time the supplier completing this form has been doing business in the MA.

Months \_\_\_\_\_ Years \_\_\_\_\_

**(C) Number of Locations** \_\_\_\_\_

Indicate the total number of locations the supplier has serving the MA.

**(D) Physical Address(es)**

If the supplier's physical address is not the same as the mailing address shown in Item (2F), provide the supplier's complete physical address. PO boxes and drop boxes are not acceptable. A supplier's physical address is where it conducts business with its customers. Lines 1, 2 and 3 should correspond to the same lines in Item (3A), if applicable.

(U.S. POSTAL SERVICE ABBREVIATIONS ONLY)

City

State (US)

ZIP (00000)

1	_____
2	_____
3	_____

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(3) Supplier's Business Information (Continued)****(E) Accreditation Information for Locations Serving This MA**

Provide the names of any organizations, such as JCAHO or CHCAP, that have accredited the supplier completing this form. Indicate whether the supplier was accredited with commendation and the accreditation's issue and expiration dates. Explain in Item (11) if any accreditation is for only one of several supplier locations rather than for the entire supplier organization.

Accrediting Organization	With Commendation?	Issued (MONTH-YYYY)	Expires (MONTH-YYYY)
1 _____	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
2 _____	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
3 _____	<input type="radio"/> Yes <input type="radio"/> No	_____	_____

**(F) Licensing Information for Locations Serving This MA**

Indicate any licenses issued to the supplier completing this form, which apply to the MA. Examples include a pharmacy license, a business occupancy license or a local business license. Provide the license number, the name of the licensing agency, the city and state in which the license was issued, and the license's issue and expiration dates. Explain in Item (11) if any license is for only one of several supplier locations rather than for the entire supplier organization.

License No.	Licensing Agency	City	State (US)	Issued (MONTH-YYYY)	Expires (MONTH-YYYY)
1 _____	_____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____	_____
4 _____	_____	_____	_____	_____	_____
5 _____	_____	_____	_____	_____	_____

**(G) Facility Information**

List the facilities, including the type of facility (retail storefront/showroom, warehouse or office), used by the supplier to serve this MA.

Facility Name	Type of Facility	Contact Person		Telephone No. (INCLUDE AREA CODE.)
		First	Last	
1 _____	_____	_____	_____	_____
2 _____	_____	_____	_____	_____
3 _____	_____	_____	_____	_____
4 _____	_____	_____	_____	_____

**(4) Employee Information and Training****(A) Number of Supplier's Full Time Employees Serving This MA** \_\_\_\_\_

Indicate the number of staff employed by the supplier on a full-time or full-time equivalent basis to serve customers in the MA.

**(B) Number of Supplier's Part Time/ Contracted Employees Serving This MA** \_\_\_\_\_

Indicate the number of staff employed by the supplier on a part-time or contractual basis to serve customers in the MA.

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(4) Employee Information and Training (Continued)****(C) Number of Clinicians Employed by Supplier to Serve This MA**

Indicate the number of clinicians among the supplier's full and part-time staff serving the MA.

	Full-Time	Part-Time/Contracted		Full-Time	Part-Time/Contracted
Enterostomal Therapist	_____	_____	Respiratory Therapist	_____	_____
Licensed Dietician/Nutritionist	_____	_____	Other (Explain Below)	_____	_____
Occupational Therapist	_____	_____			
Orthotist	_____	_____			
Physical Therapist	_____	_____			
Registered Nurse	_____	_____			
Registered Pharmacist	_____	_____			

**(D) Does the supplier have an internal policy and procedure manual?** ☐ Yes ☐ No

Indicate whether or not the supplier has and uses in the MA an internal policy and procedure manual, which is used to train employees and outlines operating procedures and guidelines. The manual may cover item delivery and setup, customer and caregiver instruction and customer service. If the supplier has no policy and procedure manual, attach samples of procedures/protocols used instead of a manual or explain the same in Item (11).

**(E) Average Number of Supplier's In-Service Training Sessions Held Monthly in This MA** \_\_\_\_\_ per month

The number may include training provided by management, manufacturers, clinicians, industry organizations and consultants as well as external training seminars. If none, attach samples of procedures/protocols used instead of in-service training sessions or explain same in Item (11). Select pages are sufficient. Do not attach documents in their entirety.

**(5) Customer Complaints**

Describe the supplier's protocol for documenting and resolving complaints and grievances from customers in this MA. Attach a sample of logs and/or other documents used. If the supplier does not already have a protocol in place, explain how the supplier plans to document and resolve complaints and grievances from customers in the MA during the demonstration cycle. Samples of proposed logs or other methods of documentation must be attached.

**(6) Customer Satisfaction****(A) Does the supplier have its customers complete satisfaction surveys?** ☐ Yes ☐ No

Surveys may be conducted in writing or over the telephone.

**(B) If (6A) is "Yes," are results from the last six months attached?** ☐ Yes ☐ No

If (6A) is "Yes," the supplier must submit a compilation or summary of the past six months' results.

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(6) Customer Satisfaction (Continued)****(C) If no surveys are used, how does the supplier measure and ensure customer satisfaction?**

If (6A) is "No," the supplier must describe how it determines customers' level of satisfaction for the MA.

**(D) Who resolves after-hours telephone calls?**☐ Clinician☐ Manager☐ Technician☐ Other (Explain Below)

Select the appropriate title of the individual(s) who routinely resolves after-hours telephone calls from customers in the MA. If it is the practice of the supplier to use an answering service after hours, provide the title of the individual(s) normally on-call to receive telephone calls forwarded by the answering service. More than one title may be selected. If "Other," explain below.

**(E) Does the supplier have an emergency/disaster plan?**☐ Yes ☐ No

Indicate whether or not the supplier has an emergency disaster plan that outlines its procedures for ensuring continuous customer care and safety during emergencies or disasters in the MA. Examples include prolonged power outages and natural disasters such as hurricanes, tornados, floods, etc. If "No," the supplier must attach samples of procedures/protocols used instead of an emergency/disaster plan or explain the same in Item (11). Select pages are sufficient. Do not attach documents in their entirety.

**(F) Does the supplier have an infection control program?**☐ Yes ☐ No

Indicate whether or not the supplier has and enforces infection control procedures in the MA. If "No," the supplier must attach samples of procedures/protocols used instead of an infection control program or explain the same in Item (11). Select pages are sufficient. Do not attach documents in their entirety.

**(G) In the event of a manufacturer recall, are items tracked by the supplier so they can be located?**☐ Yes ☐ No

Indicate whether or not the supplier has a mechanism for tracking and locating items in the MA if a manufacturer recalls items provided by the supplier to its customers. If "No," the supplier must attach samples of procedures/protocols used to locate items if recalled or explain the same in Item (11). Select pages are sufficient. Do not attach documents in their entirety.

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(7) Referral Source References**

Name five or more referral sources who normally refer patients residing in this MA to the supplier for items in the product category (or categories) on which the supplier or network is bidding. Include contact names and telephone numbers. The Bid Evaluation Panel will expect to receive a completed Form E directly from each referral source before the bid submission deadline.

	Organization Name	Contact Person		Telephone No. (INCLUDE AREA CODE.)
		First	Last	
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____

**(8) Declarations**

- (A) Has any action ever been taken against the supplier's operating license in any state? ☐ Yes ☐ No
- (B) Is licensing action pending against the supplier in any state at this time? ☐ Yes ☐ No
- (C) Is the supplier or owner/manager currently under investigation by a regulatory, professional or licensing agency such as Medicare or Medicaid? ☐ Yes ☐ No
- (D) Has the supplier ever been fined by, expelled or suspended from receiving payment by Medicare or Medicaid? ☐ Yes ☐ No
- (E) Has the supplier or its medical director, owner or manager ever been required to make a payment to any plaintiff relative to a professional or product liability suit? ☐ Yes ☐ No
- (F) Is there currently any malpractice action pending against the supplier's medical director (if applicable)? ☐ Yes ☐ No ☐ N/A
- (G) Has liability insurance ever been denied, canceled, not renewed or surcharged? ☐ Yes ☐ No
- (H) Has any of the supplier's professional staff ever had any action taken against his or her professional license, registration or certification? ☐ Yes ☐ No
- (I) Has the supplier ever filed for bankruptcy? ☐ Yes ☐ No
- (J) Explain in Item (11) those instances where the supplier has answered "Yes" to questions (A) through (I). Include the date of the action and the supplier's current status. A "Yes" will not preclude the supplier from participating in the demonstration.

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(9) Bank References**

List the supplier's primary banks or other financial institutions with which it does business. Include the supplier's line of credit with the institution, account number(s), contact name and telephone number. The Bid Evaluation Panel will expect to receive a completed Form D directly from each bank reference before the bid submission deadline.

	Institution Name	Line of Credit (IF ANY, IN DOLLARS)
1	<div>Account No.</div> <div>Contact Person First Last</div>	<div>Telephone No. (INCLUDE AREA CODE.)</div>
2	<div>Account No.</div> <div>Contact Person First Last</div>	<div>Telephone No. (INCLUDE AREA CODE.)</div>
3	<div>Account No.</div> <div>Contact Person First Last</div>	<div>Telephone No. (INCLUDE AREA CODE.)</div>

**(10) Product Categories**

Select each product category for which the supplier or network is submitting a bid.

☐ Non-Customized Orthotic Devices☐ Hospital Beds & Accessories☐ Manual Wheelchairs & Accessories☐ Nebulizer Inhalation Drugs☐ Oxygen Contents, Equipment & Supplies**(11) Additional Information (Optional)**

Use this space to explain answers for Items (4D) and (4E), (6E) through (6G) and (8A) through (8I). The space provided may also be used if additional room is needed to respond to other questions on this form. This section is continued on the next page.

**Form A: Application for Suppliers**

Supplier's Legal Name (from page 1) \_\_\_\_\_

**(11) Additional Information (Continued)****(12) Authorized Representative**

I certify, as an authorized representative of the supplier, that all information submitted is complete and correct to the best of my knowledge and belief. I understand that misrepresentations, errors and omissions may result in denial or dismissal from the Medicare DMEPOS Competitive Bidding Demonstration. I agree that the supplier will fulfill the obligations of its demonstration status, including meeting or exceeding the demonstration requirements and standards, as stated in the Request for Bids. In addition, I agree that the supplier will abide by the terms and conditions of the bid process as stated in the Request for Bids. Finally, I authorize the Health Care Financing Administration and its agents to consult with persons and organizations that may provide information relative to the supplier's bids.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Definitions of the choices provided in Item (2B) of this form, Type of Business, are shown below.

**Business Corporation:** A business corporation is a commercial enterprise or establishment comprised of many employees and is legally recognized as a separate entity.

**General Partnership:** A general partnership is a contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in a proportion of profits and losses.

**Joint Venture:** A joint venture is a business that is co-owned by another individual, organization or business.

**Professional Corporation:** A professional corporation is a commercial enterprise or establishment engaged in a specific activity or area of expertise comprised of one or more employees who are educated in the specific activity or area of expertise. A professional corporation is legally recognized as a separate entity.

**Sole Proprietorship:** A sole proprietorship is an individual who is registered as a business and has been issued a federal employer identification number by the IRS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 11 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Medicare DMEPOS  
Competitive Bidding Demonstration**

**Form B: Bidding Sheet for  
Hospital Beds & Accessories**

**Supplier's Legal Name (from Form A):**

Indicate the Primary Supplier's name if this is a network's bid.

Please read the instructions carefully. Incomplete, or incorrectly completed, forms will be returned to the supplier or network.

San Antonio, Texas

Metropolitan Area (MA)

- (1) What was the total revenue collected in this MA by the supplier or network for this product category during the past year (fiscal or calendar)? All subsequent questions must be answered for the same fiscal or calendar year. Estimates are acceptable.

☐ \$0 - \$250,000      ☐ \$250,000 - \$500,000      ☐ \$500,000 - \$750,000      ☐ \$750,000 - \$1 million  
☐ \$1 million - \$3 million      ☐ \$3 million - \$6 million      ☐ \$6 million - \$10 million      ☐ More than \$10 million

- (2) What percentage of the total revenue in (1) was collected from Medicare for this product category? Estimates are acceptable.

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (3) What was the total number of customers served in this MA by the supplier or network for this product category during the past year? Estimates are acceptable.

☐ 0 - 25      ☐ 26 - 50      ☐ 51 - 75      ☐ 76 - 100      ☐ 101 - 300  
☐ 301 - 500      ☐ 501 - 750      ☐ 751 - 1,000      ☐ More than 1,000

- (4) What percentage of the total customers in (3) were Medicare beneficiaries for this product category?

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (5) Does the supplier or network have a call-back procedure in this MA for this product category after initial delivery is made to a customer? ☐ Yes ☐ No

- (6) If (5) is "Yes," how many hours after initial delivery does the supplier or network contact the customer? Contact may be made by telephone or in writing.

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (7) If (5) is "No," explain how the supplier or network follows-up with customers once initial delivery of items is made.

- (8) What is the supplier or network's method of delivery to customers in this MA for this product category? Select all that apply.

☐ United Parcel Service (UPS)      ☐ U.S. Mail      ☐ Company Vehicle      ☐ Courier Service      ☐ Other (Explain Below)

## Form B: Bidding Sheet for Hospital Beds & Accessories

Supplier's Legal Name (from page 1) \_\_\_\_\_

- (9) What type of supplier or network employee typically delivers items in this product category to customers in this MA? Select all that apply.

☐ Clinician

☐ Technician

☐ Other (Explain Below)

- (10) From the time an emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (11) From the time a non-emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (12) How does the supplier or network train customers in this MA to properly use items in this product category? If written instructions are used, include samples. If verbal instruction is provided, briefly describe how the supplier or network ensures the customer has been properly trained.

☐ In Writing (Attach Samples)

☐ Verbally (Explain Below)

- (13) The supplier or network may use this space to elaborate upon its answers to earlier questions, if desired, including Items (10) and (11).

- (14) Select the service areas within this MA that the supplier or network proposes to serve for this product category during this demonstration. More than one may be selected.

☐ Select Entire Demonstration Site

☐ Bexar County

☐ Comal County

☐ Guadalupe County

- (15) To what extent will the supplier be required to subcontract with other companies in order to provide the items and services expected of Demonstration Suppliers to the service areas indicated in Item (14)? Select one.

☐ None

☐ Some

☐ All

## Form B: Bidding Sheet for Hospital Beds & Accessories

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
E0250RRKH	Hospital Bed, Fixed Height, with any type Side Rails, with Mattress	Rental (CR15)	\$
E0255RRKH	Hospital Bed, Variable Height (Hi-Lo), with any type Side Rails, with Mattress	Rental (CR15)	\$
E0260RRKH	Hospital Bed, Semi-Electric (Head and Foot Adjustment), with any type Side Rails, with Mattress	Rental (CR15)	\$
E0261RRKH	Hospital Bed, Semi-Electric (Head and Foot Adjustment), with any type Side Rails, without Mattress	Rental (CR15)	\$
E0265RRKH	Hospital Bed, Total Electric (Head, Foot and Height Adjustment), with any type Side Rails, with Mattress	Rental (CR15)	\$
E0266RRKH	Hospital Bed, Total Electric (Head, Foot and Height Adjustment), with any type Side Rails, without Mattress	Rental (CR15)	\$
E0271NU	Mattress, Innerspring	Purchase	\$
E0272NU	Mattress, Foam Rubber	Purchase	\$
E0280NU	Bed Cradle, Any Type	Purchase	\$
E0290RRKH	Hospital Bed, Fixed Height, without Side Rails, with Mattress	Rental (CR15)	\$
E0292RRKH	Hospital Bed, Variable Height (Hi-Lo), without Side Rails, with Mattress	Rental (CR15)	\$
E0294RRKH	Hospital Bed, Semi-Electric (Head and Foot Adjustment), without Side Rails, with Mattress	Rental (CR15)	\$
E0295RRKH	Hospital Bed, Semi-Electric (Head and Foot Adjustment), without Side Rails, without Mattress	Rental (CR15)	\$
E0305RRKH	Bed Side Rails, Half Length	Rental (CR15)	\$
E0310NU	Bed Side Rails, Full Length	Purchase	\$
E0910RRKH	Trapeze Bars, A/K/A Patient Helper, attached to Bed, with Grab Bar	Rental (CR15)	\$
E0940RRKH	Trapeze Bar, Free Standing, Complete with Grab Bar	Rental (CR15)	\$
K0456RRKH	Hospital Bed, Heavy Duty, Extra Wide, With any type side rails	Rental (CR15)	\$

CR15: The item belongs in the capped-rental category.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 27 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Medicare DMEPOS  
Competitive Bidding Demonstration**

**Form B: Bidding Sheet for  
Oxygen Contents, Equipment & Supplies**

**Please read the instructions carefully. Incomplete, or incorrectly  
completed, forms will be returned to the supplier or network.**

**Supplier's Legal Name (from Form A):**

Indicate the Primary Supplier's name if this is a  
network's bid.

San Antonio, Texas

**Metropolitan Area (MA)**

- (1) What was the total revenue collected in this MA by the supplier or network for this product category during the past year (fiscal or calendar)? All subsequent questions must be answered for the same fiscal or calendar year. Estimates are acceptable.

☐ \$0 - \$250,000      ☐ \$250,000 - \$500,000      ☐ \$500,000 - \$750,000      ☐ \$750,000 - \$1 million  
☐ \$1 million - \$3 million      ☐ \$3 million - \$6 million      ☐ \$6 million - \$10 million      ☐ More than \$10 million

- (2) What percentage of the total revenue in (1) was collected from Medicare for this product category? Estimates are acceptable.

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (3) What was the total number of customers served in this MA by the supplier or network for this product category during the past year? Estimates are acceptable.

☐ 0 - 25      ☐ 26 - 50      ☐ 51 - 75      ☐ 76 - 100      ☐ 101 - 300  
☐ 301 - 500      ☐ 501 - 750      ☐ 751 - 1,000      ☐ More than 1,000

- (4) What percentage of the total customers in (3) were Medicare beneficiaries for this product category?

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (5) Does the supplier or network have a call-back procedure in this MA for this product category after initial delivery is made to a customer? ☐ Yes      ☐ No

- (6) If (5) is "Yes," how many hours after initial delivery does the supplier or network contact the customer? Contact may be made by telephone or in writing.

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (7) If (5) is "No," explain how the supplier or network follows-up with customers once initial delivery of items is made.

- (8) What is the supplier or network's method of delivery to customers in this MA for this product category? Select all that apply.

☐ United Parcel Service (UPS)      ☐ U.S. Mail      ☐ Company Vehicle      ☐ Courier Service      ☐ Other (Explain Below)

## Form B: Bidding Sheet for Oxygen Contents, Equipment & Supplies

Supplier's Legal Name (from page 1) \_\_\_\_\_

- (9) What type of supplier or network employee typically delivers items in this product category to customers in this MA? Select all that apply.

☐ Clinician

☐ Technician

☐ Other (Explain Below)

- (10) From the time an emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (11) From the time a non-emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (12) How does the supplier or network train customers in this MA to properly use items in this product category? If written instructions are used, include samples. If verbal instruction is provided, briefly describe how the supplier or network ensures the customer has been properly trained.

☐ In Writing (Attach Samples)

☐ Verbally (Explain Below)

- (13) The supplier or network may use this space to elaborate upon its answers to earlier questions, if desired, including Items (10) and (11).

- (14) Select the service areas within this MA that the supplier or network proposes to serve for this product category during this demonstration. More than one may be selected.

☐ Select Entire Demonstration Site

☐ Bexar County

☐ Comal County

☐ Guadalupe County

- (15) To what extent will the supplier be required to subcontract with other companies in order to provide the items and services expected of Demonstration Suppliers to the service areas indicated in Item (14)? Select one.

☐ None

☐ Some

☐ All

## Form B: Bidding Sheet for Oxygen Contents, Equipment & Supplies

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
E0424RR	Stationary compressed gaseous oxygen system, rental; includes contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing; 1 unit = 50 cubic ft.	Rental (LOMN)	\$
E0431RR	Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	Rental (LOMN)	\$
E0434RR	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing	Rental (LOMN)	\$
E0439RR	Stationary liquid oxygen system, rental; includes use of reservoir, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing; 1 unit = 10 lbs.	Rental (LOMN)	\$
E0441	Oxygen contents, gaseous, per unit (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned; 1 unit = 50 cubic ft.)	Purchase	\$
E0442	Oxygen contents, liquid, per unit (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned; 1 unit = 10 lbs.)	Purchase	\$
E0443	Portable oxygen contents, gaseous, per unit (for use only with portable gaseous systems when no stationary gas or liquid system is used; 1 unit = 5 cubic ft.)	Purchase	\$
E1390RR	Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	Rental (LOMN)	\$
E1405RR	Oxygen and water vapor enriching system with heated delivery	Rental (LOMN)	\$
E1406RR	Oxygen and water vapor enriching system without heated delivery	Rental (LOMN)	\$

LOMN: Length of Medical Need

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 27 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Medicare DMEPOS  
Competitive Bidding Demonstration**

**Form B: Bidding Sheet for  
Manual Wheelchairs & Accessories**

**Supplier's Legal Name (from Form A):**

Indicate the Primary Supplier's name if this is a network's bid.

**Please read the instructions carefully. Incomplete, or incorrectly completed, forms will be returned to the supplier or network.**

San Antonio, Texas

Metropolitan Area (MA)

- (1) What was the total revenue collected in this MA by the supplier or network for this product category during the past year (fiscal or calendar)? All subsequent questions must be answered for the same fiscal or calendar year. Estimates are acceptable.

☐ \$0 - \$250,000      ☐ \$250,000 - \$500,000      ☐ \$500,000 - \$750,000      ☐ \$750,000 - \$1 million  
☐ \$1 million - \$3 million      ☐ \$3 million - \$6 million      ☐ \$6 million - \$10 million      ☐ More than \$10 million

- (2) What percentage of the total revenue in (1) was collected from Medicare for this product category? Estimates are acceptable.

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (3) What was the total number of customers served in this MA by the supplier or network for this product category during the past year? Estimates are acceptable.

☐ 0 - 25      ☐ 26 - 50      ☐ 51 - 75      ☐ 76 - 100      ☐ 101 - 300  
☐ 301 - 500      ☐ 501 - 750      ☐ 751 - 1,000      ☐ More than 1,000

- (4) What percentage of the total customers in (3) were Medicare beneficiaries for this product category?

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (5) Does the supplier or network have a call-back procedure in this MA for this product category after initial delivery is made to a customer? ☐ Yes      ☐ No

- (6) If (5) is "Yes," how many hours after initial delivery does the supplier or network contact the customer? Contact may be made by telephone or in writing.

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (7) If (5) is "No," explain how the supplier or network follows-up with customers once initial delivery of items is made.

- (8) What is the supplier or network's method of delivery to customers in this MA for this product category? Select all that apply.

☐ United Parcel Service (UPS)      ☐ U.S. Mail      ☐ Company Vehicle      ☐ Courier Service      ☐ Other (Explain Below)

**Form B: Bidding Sheet for Manual Wheelchairs & Accessories**

Supplier's Legal Name (from page 1) \_\_\_\_\_

(9) What type of supplier or network employee typically delivers items in this product category to customers in this MA? Select all that apply.

☐ Clinician

☐ Technician

☐ Other (Explain Below)

(10) From the time an emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

(11) From the time a non-emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

(12) How does the supplier or network train customers in this MA to properly use items in this product category? If written instructions are used, include samples. If verbal instruction is provided, briefly describe how the supplier or network ensures the customer has been properly trained.

☐ In Writing (Attach Samples)

☐ Verbally (Explain Below)

(13) The supplier or network may use this space to elaborate upon its answers to earlier questions, if desired, including Items (10) and (11).

(14) Select the service areas within this MA that the supplier or network proposes to serve for this product category during this demonstration. More than one may be selected.

☐ Select Entire Demonstration Site

☐ Bexar County

☐ Comal County

☐ Guadalupe County

(15) To what extent will the supplier be required to subcontract with other companies in order to provide the items and services expected of Demonstration Suppliers to the service areas indicated in Item (14)? Select one.

☐ None

☐ Some

☐ All

**Form B: Bidding Sheet for Manual Wheelchairs & Accessories**

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
E1031RRKH	Rollabout chair any and all types with castors 5" or greater	Rental (CR15)	\$
K0001RRKH	Standard wheelchair	Rental (CR15)	\$
K0002RRKH	Standard hemi (low seat) wheelchair	Rental (CR15)	\$
K0003RRKH	Lightweight wheelchair	Rental (CR15)	\$
K0004RRKH	High strength, lightweight wheelchair	Rental (CR15)	\$
K0005NU	Ultralightweight wheelchair	Purchase	\$
K0006RRKH	Heavy duty wheelchair	Rental (CR15)	\$
K0007RRKH	Extra heavy duty wheelchair	Rental (CR15)	\$
K0015NU	Detachable, non-adjustable height armrest, each	Purchase	\$
K0016NU	Detachable, adjustable height armrest, complete assembly, each	Purchase	\$
K0020NU	Fixed, adjustable height armrest, pair	Purchase	\$
K0021NU	Anti-tipping device, each	Purchase	\$
K0023NU	Solid back insert, planar back, single density foam, attached with straps	Purchase	\$
K0024NU	Solid back insert, planar back, single density foam, with adjustable hook-on hardware	Purchase	\$
K0025NU	Hook-on headrest extension	Purchase	\$
K0028NU	Fully reclining back	Purchase	\$
K0030NU	Solid seat insert, planar seat, single density foam	Purchase	\$
K0031NU	Safety belt/pelvic strap	Purchase	\$
K0032NU	Seat upholstery for ultralightweight or high strength lightweight wheelchair	Purchase	\$
K0033NU	Seat upholstery for wheelchair type other than ultralightweight or high strength lightweight wheelchair	Purchase	\$

**Form B: Bidding Sheet for Manual Wheelchairs & Accessories**

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
K0034NU	Heel loop, each	Purchase	\$
K0035NU	Heel loop with ankle strap, each	Purchase	\$
K0036NU	Toe loop, each	Purchase	\$
K0037NU	High mount flip-up footrest, each	Purchase	\$
K0038NU	Leg strap, each	Purchase	\$
K0039NU	Leg strap, H style, each	Purchase	\$
K0040NU	Adjustable angle footplate, each	Purchase	\$
K0041NU	Large size footplate, each	Purchase	\$
K0042NU	Standard size footplate, each	Purchase	\$
K0043NU	Footrest, lower extension tube, each	Purchase	\$
K0045NU	Footrest, complete assembly	Purchase	\$
K0048NU	Elevating legrest, complete assembly	Purchase	\$
K0049NU	Calf pad, each	Purchase	\$
K0052NU	Swingaway, detachable footrest, each	Purchase	\$
K0053NU	Elevating footrests, articulating (telescoping), each	Purchase	\$
K0054NU	Seat width of 10", 11", 12", 15", 17", or 20" for a high strength, lightweight or ultralightweight wheelchair	Purchase	\$
K0055NU	Seat of 15", 17", or 18" for a high strength, lightweight or ultralightweight wheelchair	Purchase	\$
K0056NU	Seat height <17" or equal to or greater than 21" for a high strength, lightweight or ultralightweight wheelchair	Purchase	\$
K0057NU	Seat 19" or 20" for heavy duty or extra heavy duty chair	Purchase	\$
K0059NU	Plastic coated handrim, each	Purchase	\$

# Form B: Bidding Sheet for Manual Wheelchairs & Accessories

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
K0062NU	Handrim with 8–10 vertical or oblique projections, each	Purchase	\$
K0063NU	Handrim with 12–16 vertical or oblique projections, each	Purchase	\$
K0064NU	Zero pressure tube (flat free inserts), any size, each	Purchase	\$
K0066NU	Solid tire, any size, each	Purchase	\$
K0067NU	Pneumatic tire, any size, each	Purchase	\$
K0068NU	Pneumatic tire tube, each	Purchase	\$
K0070NU	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each	Purchase	\$
K0071NU	Front caster assembly, complete, with pneumatic tire, each	Purchase	\$
K0072NU	Front caster assembly, complete, with semi-pneumatic tire, each	Purchase	\$
K0073NU	Caster pin lock, each	Purchase	\$
K0075NU	Semi-pneumatic caster tire, any size, each	Purchase	\$
K0077NU	Front caster assembly, complete, with solid tire, each	Purchase	\$
K0079NU	Wheel lock extension, pair	Purchase	\$
K0080NU	Anti-rollback device, pair	Purchase	\$
K0081NU	Wheel lock assembly, complete, each	Purchase	\$
K0100NU	Amputee adapter, pair	Purchase	\$
K0101RRKH	One-arm drive attachment	Rental (CR15)	\$
K0103NU	Transfer board, <25"	Purchase	\$
K0104NU	Cylinder tank carrier	Purchase	\$
K0106NU	Arm trough, each	Purchase	\$

**Form B: Bidding Sheet for Manual Wheelchairs & Accessories**

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
K0195RRKH	Elevating legrests, pair (for use with capped rental wheelchair base)	Rental (CR15)	\$
K0452NU	Wheelchair bearings, any type	Purchase	\$

CR15: The item belongs in the capped-rental category.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 27 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Medicare DMEPOS  
Competitive Bidding Demonstration**

**Form B: Bidding Sheet for  
Non-Customized Orthotic Devices**

**Supplier's Legal Name (from Form A):**

Indicate the Primary Supplier's name if this is a network's bid.

Please read the instructions carefully. Incomplete, or incorrectly completed, forms will be returned to the supplier or network.

San Antonio, Texas

Metropolitan Area (MA)

- (1) What was the total revenue collected in this MA by the supplier or network for this product category during the past year (fiscal or calendar)? All subsequent questions must be answered for the same fiscal or calendar year. Estimates are acceptable.

☐ \$0 - \$250,000      ☐ \$250,000 - \$500,000      ☐ \$500,000 - \$750,000      ☐ \$750,000 - \$1 million  
☐ \$1 million - \$3 million      ☐ \$3 million - \$6 million      ☐ \$6 million - \$10 million      ☐ More than \$10 million

- (2) What percentage of the total revenue in (1) was collected from Medicare for this product category? Estimates are acceptable.

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (3) What was the total number of customers served in this MA by the supplier or network for this product category during the past year? Estimates are acceptable.

☐ 0 - 25      ☐ 26 - 50      ☐ 51 - 75      ☐ 76 - 100      ☐ 101 - 300  
☐ 301 - 500      ☐ 501 - 750      ☐ 751 - 1,000      ☐ More than 1,000

- (4) What percentage of the total customers in (3) were Medicare beneficiaries for this product category?

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (5) Does the supplier or network have a call-back procedure in this MA for this product category after initial delivery is made to a customer?

☐ Yes      ☐ No

- (6) If (5) is "Yes," how many hours after initial delivery does the supplier or network contact the customer? Contact may be made by telephone or in writing.

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (7) If (5) is "No," explain how the supplier or network follows-up with customers once initial delivery of items is made.

- (8) What is the supplier or network's method of delivery to customers in this MA for this product category? Select all that apply.

☐ United Parcel Service (UPS)      ☐ U.S. Mail      ☐ Company Vehicle      ☐ Courier Service      ☐ Other (Explain Below)

## Form B: Bidding Sheet for Non-Customized Orthotic Devices

Supplier's Legal Name (from page 1) \_\_\_\_\_

- (9) What type of supplier or network employee typically delivers items in this product category to customers in this MA? Select all that apply.

☐ Clinician

☐ Technician

☐ Other (Explain Below)

- (10) From the time an emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (11) From the time a non-emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours

☐ 6 - 12 hours

☐ 12 - 18 hours

☐ 18 - 24 hours

☐ 24 - 48 hours

☐ More than 48 hours

- (12) How does the supplier or network train customers in this MA to properly use items in this product category? If written instructions are used, include samples. If verbal instruction is provided, briefly describe how the supplier or network ensures the customer has been properly trained.

☐ In Writing (Attach Samples)

☐ Verbally (Explain Below)

- (13) The supplier or network may use this space to elaborate upon its answers to earlier questions, if desired, including Items (10) and (11).

- (14) Select the service areas within this MA that the supplier or network proposes to serve for this product category during this demonstration. More than one may be selected.

☐ Select Entire Demonstration Site

☐ Bexar County

☐ Comal County

☐ Guadalupe County

- (15) To what extent will the supplier be required to subcontract with other companies in order to provide the items and services expected of Demonstration Suppliers to the service areas indicated in Item (14)? Select one.

☐ None

☐ Some

☐ All

# Form B: Bidding Sheet for Non-Customized Orthotic Devices

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
L1800	KO, elastic with stays	Purchase	\$
L1810	KO, elastic with joints	Purchase	\$
L1815	KO, elastic or other elastic type material with condylar pad(s)	Purchase	\$
L1820	KO, elastic with condylar pads and joints	Purchase	\$
L1825	KO, elastic knee cap	Purchase	\$
L1830	KO, immobilizer, canvas longitudinal	Purchase	\$
L1832	KO, adjustable knee joints, positional orthosis, rigid support	Purchase	\$
L1850	KO, Swedish type	Purchase	\$
L1902	AFO, ankle gauntlet	Purchase	\$
L1906	AFO, multiligamentous ankle support	Purchase	\$
L1930	AFO, Plastic	Purchase	\$
L2112	AFO, fracture orthosis, tibial fracture cast orthosis, soft	Purchase	\$
L2114	AFO, fracture orthosis, tibial fracture cast orthosis molded to patient, semi rigid	Purchase	\$
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid	Purchase	\$
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft	Purchase	\$
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid	Purchase	\$
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid	Purchase	\$
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints	Purchase	\$
L2182	Addition to lower extremity fracture orthosis drop lock knee joint	Purchase	\$
L2210	Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint	Purchase	\$

# Form B: Bidding Sheet for Non-Customized Orthotic Devices

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
L2220	Addition to lower extremity, dorsiflexion assist (plantar flexion assist/resist, each joint	Purchase	\$
L3650	SO, figure of eight design abduction restrainer	Purchase	\$
L3660	SO, figure of eight design abduction restrainer, canvas and webbing	Purchase	\$
L3670	SO, acromio/clavicular (canvas and webbing type)	Purchase	\$
L3700	EO, elastic with stays	Purchase	\$
L3720	EO, durable upright with forearm/arm cuffs, free motion	Purchase	\$
L3730	EO, double upright with forearm/arm cuffs, extension/flexion	Purchase	\$
L3800	WHFO, short opponens, no attachment	Purchase	\$
L3805	WHFO, long opponens, no attachment	Purchase	\$
L3810	WHFO, addition to short and long opponens, thumb abduction (C) bar	Purchase	\$
L3825	WHFO, addition to short and long opponens, MP extension assist stop	Purchase	\$
L3840	WHFO, addition to short and long opponens, spring swivel thumb	Purchase	\$
L3850	WHO, addition to short and long opponens, action wrist, with dorsiflexion assist	Purchase	\$
L3855	WHFO, addition to short and long opponens, adjustable MP flexion control	Purchase	\$
L3860	WHFO, addition to short and long opponens, adjustable MP flexion control and IP	Purchase	\$
L3980	Upper extremity fracture orthosis, humeral	Purchase	\$
L3982	Upper extremity fracture orthosis, radius/ulnar	Purchase	\$
L3984	Upper extremity fracture orthosis, wrist	Purchase	\$
L3985	Upper extremity fracture orthosis forearm, hand with wrist hinge	Purchase	\$
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each	Purchase	\$

**Form B: Bidding Sheet for Non-Customized Orthotic Devices**

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
L4350	Pneumatic ankle control splint (e.g. aircast)	Purchase	\$
L4360	Pneumatic walking splint (e.g. aircast)	Purchase	\$
L4380	Pneumatic knee splint (e.g. aircast)	Purchase	\$
L4392	Replace soft interface material, ankle contracture splint	Purchase	\$
L4396	Ankle contracture splint	Purchase	\$
L4398	Foot drop splint, recumbent positioning device	Purchase	\$

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 27 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Medicare DMEPOS  
Competitive Bidding Demonstration**

**Form B: Bidding Sheet for  
Nebulizer Inhalation Drugs**

Please read the instructions carefully. Incomplete, or incorrectly  
completed, forms will be returned to the supplier or network.

**Supplier's Legal Name (from Form A):**

Indicate the Primary Supplier's name if this is a  
network's bid.

San Antonio, Texas

Metropolitan Area (MA)

- (1) What was the total revenue collected in this MA by the supplier or network for this product category during the past year (fiscal or calendar)? All subsequent questions must be answered for the same fiscal or calendar year. Estimates are acceptable.

☐ \$0 - \$250,000      ☐ \$250,000 - \$500,000      ☐ \$500,000 - \$750,000      ☐ \$750,000 - \$1 million  
☐ \$1 million - \$3 million      ☐ \$3 million - \$6 million      ☐ \$6 million - \$10 million      ☐ More than \$10 million

- (2) What percentage of the total revenue in (1) was collected from Medicare for this product category? Estimates are acceptable.

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (3) What was the total number of customers served in this MA by the supplier or network for this product category during the past year? Estimates are acceptable.

☐ 0 - 25      ☐ 26 - 50      ☐ 51 - 75      ☐ 76 - 100      ☐ 101 - 300  
☐ 301 - 500      ☐ 501 - 750      ☐ 751 - 1,000      ☐ More than 1,000

- (4) What percentage of the total customers in (3) were Medicare beneficiaries for this product category?

☐ 0% - 10%      ☐ 11% - 20%      ☐ 21% - 30%      ☐ 31% - 40%      ☐ 41% - 50%  
☐ 51% - 60%      ☐ 61% - 70%      ☐ 71% - 80%      ☐ 81% - 90%      ☐ 91% - 100%

- (5) Does the supplier or network have a call-back procedure in this MA for this product category after initial delivery is made to a customer?

☐ Yes      ☐ No

- (6) If (5) is "Yes," how many hours after initial delivery does the supplier or network contact the customer? Contact may be made by telephone or in writing.

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (7) If (5) is "No," explain how the supplier or network follows-up with customers once initial delivery of items is made.

- (8) What is the supplier or network's method of delivery to customers in this MA for this product category? Select all that apply.

☐ United Parcel Service (UPS)      ☐ U.S. Mail      ☐ Company Vehicle      ☐ Courier Service      ☐ Other (Explain Below)

## Form B: Bidding Sheet for Nebulizer Inhalation Drugs

Supplier's Legal Name (from page 1) \_\_\_\_\_

- (9) What type of supplier or network employee typically delivers items in this product category to customers in this MA? Select all that apply.
- ☐ Clinician                      ☐ Technician                      ☐ Other (Explain Below)

- (10) From the time an emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (11) From the time a non-emergency order is placed, how long does it typically take the supplier or network to deliver items in this product category to customers in this MA?

☐ 1 - 6 hours      ☐ 6 - 12 hours      ☐ 12 - 18 hours      ☐ 18 - 24 hours      ☐ 24 - 48 hours      ☐ More than 48 hours

- (12) How does the supplier or network train customers in this MA to properly use items in this product category? If written instructions are used, include samples. If verbal instruction is provided, briefly describe how the supplier or network ensures the customer has been properly trained.

☐ In Writing (Attach Samples)      ☐ Verbally (Explain Below)

- (13) The supplier or network may use this space to elaborate upon its answers to earlier questions, if desired, including Items (10) and (11).

- (14) Select the service areas within this MA that the supplier or network proposes to serve for this product category during this demonstration. More than one may be selected.

☐ Select Entire Demonstration Site      ☐ Bexar County      ☐ Comal County      ☐ Guadalupe County

- (15) To what extent will the supplier be required to subcontract with other companies in order to provide the items and services expected of Demonstration Suppliers to the service areas indicated in Item (14)? Select one.

☐ None      ☐ Some      ☐ All

# Form B: Bidding Sheet for Nebulizer Inhalation Drugs

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
E0590	Monthly dispensing fee	Purchase	\$
J2545	Pentamidine isethionate, inhalation solution, per 300 mg, administered through DME	Purchase	\$
J7608KO	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram	Purchase	\$
J7608KQ	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram	Purchase	\$
J7618	Albuterol, inhalation solution administered through DME, concentrated form, per milligram	Purchase	\$
J7619KO	Albuterol, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7619KQ	Albuterol, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7628	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram	Purchase	\$
J7631KO	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams	Purchase	\$
J7631KQ	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams	Purchase	\$
J7636KO	Atropine, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7636KQ	Atropine, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7638KO	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7638KQ	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7639KO	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7639KQ	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7644KO	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7644KQ	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7659KO	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7659KQ	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$

**Form B: Bidding Sheet for Nebulizer Inhalation Drugs**

Supplier's Legal Name (from page 1) \_\_\_\_\_

A HCPCS Code	B Item Description	C Bid Type	D Bid Price
J7669KO	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams	Purchase	\$
J7669KQ	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams	Purchase	\$
J7681KO	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7681KQ	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram	Purchase	\$
J7683	Triamcinolone, administered through DME, concentrated form, per milligram	Purchase	\$
J7684KO	Triamcinolone, administered through DME, unit dose form, per milligram	Purchase	\$
J7684KQ	Triamcinolone, administered through DME, unit dose form, per milligram	Purchase	\$

KO: Single drug unit dose reimbursement

KP: Reimbursement will remain equivalent to KO when added to the first drug in a multiple drug unit dose

KQ: Second/subsequent drug, multiple drug unit dose reimbursement

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## Form C: On-Site Inspection

Supplier's Legal Name (from Form A) \_\_\_\_\_

This form is to be used by on-site inspectors who visit the facilities of bidding suppliers. For any answer, provide explanatory notes where appropriate. Bidding suppliers are not required to have each of these items. Instead, this inspection is looking for evidence that the bidder is a supplier that provides quality goods and services.

### (1) Supplier Identification

(A) In This Metropolitan Area, dba \_\_\_\_\_

(B) Physical Address Inspected \_\_\_\_\_

(C) City, State and ZIP Code \_\_\_\_\_

(D) NSC Identification No. \_\_\_\_\_

### (2) Interviewee Identification

(A) Names of Person(s) Interviewed \_\_\_\_\_

(B) Title(s) of Person(s) Interviewed \_\_\_\_\_

### (3) Facility Information

(A) Is the supplier's location an appropriate site?

If "No," explain. Inappropriate sites include drop boxes or answering services.

☐ Yes ☐ No

COMMENTS:

(B) Does the supplier's location match the physical address provided? If "No," explain.

☐ Yes ☐ No

COMMENTS:

(C) Does the supplier share office space with any other business(es)? If "Yes," explain.

☐ Yes ☐ No

COMMENTS:

(D) Is there a sign on the building or building's premises that identifies the supplier's business?

☐ Yes ☐ No

COMMENTS:

## Form C: On-Site Inspection

Supplier's Legal Name (from Form A) \_\_\_\_\_

### (3) Facility Information (Continued)

(E) Are the supplier's certificates and licenses displayed? If "Yes," list them.

☐ Yes ☐ No

COMMENTS:

### (4) Staffing Information

(A) What are the supplier's normal business hours? Include only operating office hours, not when calls are taken by an answering machine/service. Indicate a.m. or p.m. \_\_\_\_\_

(B) Is there a working telephone?

☐ Yes ☐ No

(C) Is there enough staff available during normal business hours to provide customer service over the telephone?

☐ Yes ☐ No

(D) If the supplier provides retail services is there staff available to serve customers in person?

☐ Yes ☐ No

(E) Does the supplier's staff receive all incoming telephone calls directly during normal business hours?

☐ Yes ☐ No

(F) Are calls ever routed to an answering service/machine? If "Yes," when and for how long?

☐ Yes ☐ No

COMMENTS:

(G) How are after-hours emergency calls handled? Ask the supplier to provide written instructions that explain after-hours emergency care procedures, including a business telephone number for beneficiaries to call.

COMMENTS:

### (5) Inventory

(A) Does the supplier have access to the full range of products for which it bid? If items are not readily stocked, how will they be obtained?

☐ Yes ☐ No

COMMENTS:

(B) If inventory is stored at another location, what is the storage facility's name and physical address?

☐ Yes ☐ No

COMMENTS:

## Form C: On-Site Inspection

Supplier's Legal Name (from Form A) \_\_\_\_\_

### (5) Inventory (Continued)

- (C) Does the supplier use a computer system to track inventory, billing and accounts receivable? If "Yes," have the supplier demonstrate the system and note the results.

☐ Yes ☐ No

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

- (D) Does the supplier use a computer system to automate management reports? If "Yes," have the supplier demonstrate this capability and note the results.

☐ Yes ☐ No

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

### (6) Patient File Information

Ask to randomly select at least four patients' files. For all files, check for the following items:

- (A) Physician Order (PO) ☐ Yes ☐ No
- (B) Original Certificate of Medical Necessity (CMN) if applicable ☐ Yes ☐ No ☐ N/A
- (C) Evidence of Tampering with the PO and/or CMN (correction fluid, cutting and pasting, etc.) ☐ Yes ☐ No
- (D) Written Instruction on the Function and Use of Equipment/Supplies for Beneficiaries and/or Their Caregivers ☐ Yes ☐ No
- (E) Documentation of Safety Assessments and Infection Control Procedures ☐ Yes ☐ No
- (F) A Patient-Signed Claim Form or Assignment of Benefits Form/Letter ☐ Yes ☐ No

If the answer to any of the above is "No," explain.

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

### (7) Procedure Information

- (A) Can the supplier provide the following items?
- (1) Documentation that shows protocol in the event of an emergency/disaster ☐ Yes ☐ No
- (2) Documentation that shows protocol for resolving beneficiary complaints ☐ Yes ☐ No
- (3) Documentation that shows protocol for communicating with drivers and/or delivery persons when they are out on a delivery? ☐ Yes ☐ No
- (4) Documentation of infection control procedures? ☐ Yes ☐ No
- (5) A sample "follow-up sheet" for recording and monitoring beneficiaries' use of equipment and/or supplies ☐ Yes ☐ No
- (B) Is there an internal policy and procedure manual on the premises? ☐ Yes ☐ No
- (C) Are there new-patient information packets on the premises? ☐ Yes ☐ No

## Form C: On-Site Inspection

**Supplier's Legal Name (from Form A)**

**(7) Procedure Information (Continued)**

COMMENTS:

### (8) General Comments

### (9) Inspector Identification

**(A)** Interview Completed by

**(B) Date & Time (a.m. or p.m.)**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

May 8, 2000

Dear Sir or Madam:

The Health Care Financing Administration (HCFA) is conducting a competitive bidding demonstration for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) billed to Medicare. Companies that provide certain of these items to Medicare beneficiaries permanently residing in San Antonio, TX, are competing to provide the items to fee-for-service beneficiaries.

HCFA needs your input in order to determine who the winning bidders will be. Please take the time to complete the accompanying form for the Medicare DMEPOS supplier that identified your company as a reference. Without your input, the supplier will not be able to participate in the demonstration. Please be specific.

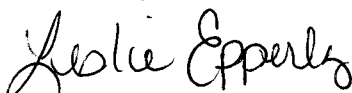
The completed form must be received **before June 23, 2000**, at the following address or fax number in order for the supplier's bid to be complete.

AG-400  
Medicare DMEPOS Competitive Bidding Demonstration  
Palmetto GBA  
PO Box 100164  
Columbia SC 29202-3164  
Fax (803) 935-0078

A self-addressed envelope has been provided for your convenience. However, certified mail is recommended as a way of tracking delivery.

For further information, contact the supplier who has named you as a reference or call (888) 289-0710 toll-free Monday through Friday between 8 a.m. and 4 p.m. Central Time. Thank you for your cooperation.

Sincerely,



Leslie Epperly  
Project Manager

**Palmetto Government Benefits Administrators, LLC**

Medicare DMEPOS Competitive Bidding Demonstration

Post Office Box 100164 • Columbia, South Carolina • 29202-3164 • (803) 788-0222 • Fax (803) 691-8943

**A HCFA Contracted Intermediary and Carrier**

## Form D: Bank Reference

This form will be used by the Bid Evaluation Panel to review the supplier's financial standing. The intent of the questionnaire is to confirm that the supplier is financially sound and able to serve expanding business in the San Antonio, TX metropolitan area. The supplier should complete Items (1), both pages, through (7) before forwarding this questionnaire to bank references. Palmetto GBA will expect to receive completed questionnaires directly from those names listed in Item (9) of Form A before the bid submission deadline. We recommend bank references use certified mail to return completed questionnaires, for tracking purposes. Addressed envelopes are provided.

### To Be Completed by the Supplier

(1) Supplier's Legal Name (from Form A)

---

(2) Name under Which Supplier Has  
Credit with This Institution

---

(3) Mailing Address

---

(4) City, State and ZIP Code

---

(5) NSC Identification No.

---

(6) Name of Bank/Financial Institution  
(from Form A)

---

(7) Account No. (from Form A)

---

### To Be Completed by the Bank Reference

(8) Has the credit holder ever failed to make a loan payment (installment and/or revolving accounts)?

☐ Yes

☐ No

(9) If (8) is "Yes," when was the last time the credit holder failed to make payment? How often does this occur?

---

---

---

(10) Has a check been returned due to insufficient funds for this credit holder in the last 12 months?

☐ Yes

☐ No

(11) If (10) is "Yes," when was the last time a check was returned? How often does this occur?

---

---

---

(12) How would you rate this customer's  
credit performance? Select one.

(Bottom 20%)

(20% - 40%)

(40% - 60%)

(60% - 80%)

(80% - 100%)

☐ Poor

☐ Fair

☐ Average

☐ Good

☐ Excellent

## Form D: Bank Reference

Supplier's Legal Name (from Form A) \_\_\_\_\_

(13) If unable to rate the customer's credit performance, please explain.

---

---

---

---

---

---

(14) For all accounts, what is the credit holder's average daily balance? \_\_\_\_\_

(15) Bank/Financial Institution \_\_\_\_\_

(16) Reference Inquiry Completed by \_\_\_\_\_

(17) Title \_\_\_\_\_

(18) Date \_\_\_\_\_

(19) Signature \_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

## Form E: Referral Source Reference

This form will be used by the Bid Evaluation Panel to review the supplier's reputation and practices in the San Antonio, TX metropolitan area. The intent of this questionnaire is to confirm that the supplier provides quality goods and services and ensures customer satisfaction. The supplier should complete Items (1), both pages, through (7) before forwarding this questionnaire to referral sources. Referral sources are those individuals, agencies or institutions that refer customers to the supplier for home medical equipment. Palmetto GBA will expect to receive completed questionnaires directly from those names listed in Item (7) of Form A before the bid submission deadline. We recommend referral sources use certified mail to return completed questionnaires, for tracking purposes. Addressed envelopes are provided.

### To Be Completed by the Supplier

(1) Supplier's Legal Name (from Form A)

---

(2) Name under Which Supplier Does Business with This Referral Organization

---

(3) Physical Address

---

(4) City, State and ZIP Code

---

(5) NSC Identification No.

---

(6) Products for Which the Supplier Is Bidding  
(Select all that apply.)

- |  |  |
|--|--|
| <input type="checkbox"/> Non-Customized Orthotic Devices       | <input type="checkbox"/> Hospital Beds & Accessories |
| <input type="checkbox"/> Manual Wheelchairs & Accessories      | <input type="checkbox"/> Nebulizer Inhalation Drugs  |
| <input type="checkbox"/> Oxygen Contents, Equipment & Supplies |  |

(7) Name of Referral Organization (from Form A)

---

### To Be Completed by the Referral Source

Compared to other suppliers with which your organization does business, how would you rate this supplier when providing the products indicated above to your patients? Please select a single response for each question.

	(Bottom 20%)	(20% - 40%)	(40% - 60%)	(60% - 80%)	(80% - 100%)
(8) Is the supplier's staff courteous?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(9) Is the supplier's staff knowledgeable?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(10) Does the supplier schedule deliveries?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(11) Are deliveries timely?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(12) Does the supplier resolve customer problems timely?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(13) Does the supplier provide quality products that meet customers' medical needs?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(14) Are customers properly trained in the use, care and cleaning of equipment?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(15) Are customers generally satisfied with the supplier's services?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent
(16) Are you satisfied with the supplier's services?	<input type="radio"/> Poor	<input type="radio"/> Fair	<input type="radio"/> Average	<input type="radio"/> Good	<input type="radio"/> Excellent

## Form E: Referral Source Reference

Supplier's Legal Name (from Form A)

(17) The space below is provided for further explanation or additional comment on the supplier's products, services and level of customer satisfaction.

[illegible]

(18) Organization

(19) Reference Inquiry Completed by

(20) Title

(21) Date

(22) Signature

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# Medicare DMEPOS Competitive Bidding Demonstration

## Form F: Financial Data

Supplier's Legal Name (from Form A)

San Antonio, Texas

Metropolitan Area (MA)

Please read the instructions carefully. Incomplete, or incorrectly completed, forms will be returned to the supplier. Data is requested for two tax years. Greater weight will be given to the most current financial information.

**Documentation of the financial information requested must be submitted with this completed form.**

Each supplier is considered to be a Service Location within the MA. However, some Service Locations may be wholly controlled by other companies. If your Service Location is NOT wholly controlled by another company, submit only your corporate tax returns and any related schedules. If your service location is wholly controlled by another company, submit tax returns and related schedules for the controlling company as well as balance sheets, aging accounts receivable reports and income statements for your Service Location. Indicate below which documentation you have attached. Documentation must be provided for the most recently filed tax year and the previously filed tax year. The supplier's bid cannot be evaluated further without copies of the supporting documentation. ☐ Tax Returns ☐ Balance Sheets ☐ AR Reports ☐ Income Statements

Range of Dates Covered by Supporting Documentation	Most Recently Filed Tax Year		Previously Filed Tax Year	
	(MONTH-YYYY)	(MONTH-YYYY)	(MONTH-YYYY)	(MONTH-YYYY)
	to		to	
	(SERVICE LOCATION)	(CONTROLLING CO.)	(SERVICE LOCATION)	(CONTROLLING CO.)
Gross Sales	\$	\$	\$	\$
Net Sales	\$	\$	\$	\$
Net Income (Loss)	\$	\$	\$	\$
Accounts Receivable	\$	\$	\$	\$
Inventories	\$	\$	\$	\$
Current Assets	\$	\$	\$	\$
Total Assets	\$	\$	\$	\$
Current Liabilities	\$	\$	\$	\$

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

May 8, 2000

Dear Nursing Home Administrator:

The Health Care Financing Administration (HCFA) is requiring Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to participate in a competitive bidding demonstration to provide certain types of DMEPOS to Medicare.

A Medicare fee schedule resulting from this demonstration will be in effect beginning January 1, 2001, for non-customized orthotic devices. Only Part B fee-for-service beneficiaries who permanently reside in the San Antonio metropolitan area are affected by this demonstration.

Because nursing homes operate in a different environment, and under different billing and reimbursement procedures than does home care, we are making some exceptions that will make it easier for the nursing homes to operate during the demonstration.

- (1) Medicare beneficiaries who are nursing home residents and whose stay is covered by Part A are not included in this demonstration. DMEPOS items for residents with Part A coverage for their stays are paid for as part of the prospective payment system.
- (2) Medicare beneficiaries who are nursing home residents and who have only Part B fee-for-service coverage are included in the demonstration. Nursing homes are urged to choose one of the Demonstration Suppliers to provide non-customized orthotics to Medicare beneficiaries. The Demonstration Suppliers selected for these products, and the demonstration fee schedule, are listed in an enclosure.

Nursing homes often have business relationships with suppliers that make it difficult to purchase non-customized orthotics from Demonstration Suppliers while purchasing these same items for other nursing home residents from the facility's usual suppliers. Therefore, HCFA will allow nursing homes to obtain non-customized orthotics from Non-Demonstration Suppliers, if you notify us of this arrangement. Medicare will reimburse Non-Demonstration Suppliers for non-customized orthotics at no more than the demonstration prices.

Claims for non-customized orthotics will be sent to the DMERC as usual by the supplier, including the nursing home if acting as a supplier. Because these claims will be reimbursed under an exception to the demonstration's guidelines, it is necessary for the nursing homes and their

**Palmetto Government Benefits Administrators, LLC**

Medicare DMEPOS Competitive Bidding Demonstration

Post Office Box 100164 • Columbia, South Carolina • 29202-3164 • (803) 788-0222 • Fax (803) 691-8943

**A HCFA Contracted Intermediary and Carrier**

suppliers to send the requested information to the DMERC. Nursing home suppliers must agree to meet the terms of the demonstration, including the quality and service standards.

A form accompanies this letter which nursing homes must complete if they plan to use Non-Demonstration Suppliers to provide non-customized orthotics. Without this information, Medicare may deny claims for these beneficiaries and these products beginning January 1, 2001. The demonstration will be in operation for two years.

If you have any questions, please call our toll-free number (888) 289-0710 between 8 a.m. and 4 p.m. Central Time. The accompanying form should be completed and returned to the address or fax number shown below before December 1, 2000.

AG-400  
Medicare DMEPOS Competitive Bidding Demonstration  
Palmetto GBA  
PO Box 100164  
Columbia SC 29202-3164  
Fax (803) 935-0078

Sincerely,



Leslie Epperly  
Project Manager

Enclosures:

List of demonstration suppliers  
List of demonstration prices  
Supplier standards  
Form G

**Medicare DMEPOS  
Competitive Bidding Demonstration**

Medicare Provider No. \_\_\_\_\_

**Form G: Suppliers for Nursing Homes**

San Antonio, Texas

Metropolitan Area

Medicare beneficiaries who are nursing home residents and who have only Part B coverage are included in this demonstration. Therefore, nursing homes in the metropolitan statistical area are urged to purchase demonstration items for these beneficiaries from Demonstration Suppliers. However, nursing homes that prefer to use Non-Demonstration Suppliers for these beneficiaries are required to list the suppliers on this form and return it to the address provided in the cover letter. Only the suppliers listed on the accompanying enclosure are Demonstration Suppliers.

**(1) Nursing Home's Identifying Information**

**(A) Nursing Home's Legal Name** \_\_\_\_\_

The official entity name under which the nursing home is authorized to do business, and which it uses when reporting to the IRS and Medicare.

**(B) Physical Address** Indicate the facility's complete physical address. PO boxes and drop boxes are not acceptable. The physical address is where the facility conducts business with its residents. Use a two-letter abbreviation for the state.

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY)

City

State (US) ZIP (00000)

First

Last

**(C) Contact Person** \_\_\_\_\_

Indicate the names of the individual at the facility who should be contacted to answer questions regarding the information provided on this form.

**(D) Telephone No.**

( ) -

**(2) Providers of Medical Supplies for Residents**

**(A) Supplier's Name:** The name under which the supplier does business with the nursing home

**NSC Identification No:** The 10-digit number the supplier uses to bill Medicare

Address from which the supplier provides items to the facility

City

State (US) ZIP (00000)

**Contact Person:** Supplier's employee with whom the nursing home is in contact

**Telephone No.**

First Name

Last Name

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices

**(B) Supplier's Name**

**NSC Identification No.**

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY)

City

State (US) ZIP (00000)

Contact Person

First Name

Last Name

Telephone No.

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices

**Form G: Suppliers for Nursing Homes**

Nursing Home's Legal Name (from page 1) \_\_\_\_\_

**(2) Providers of Medical Supplies for Residents (Continued)****(C)** Supplier's Name \_\_\_\_\_

NSC Identification No. \_\_\_\_\_

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY) \_\_\_\_\_

City \_\_\_\_\_

State (US) \_\_\_\_\_

ZIP (00000) \_\_\_\_\_

Contact Person \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Telephone No. \_\_\_\_\_

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices**(D)** Supplier's Name \_\_\_\_\_

NSC Identification No. \_\_\_\_\_

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY) \_\_\_\_\_

City \_\_\_\_\_

State (US) \_\_\_\_\_

ZIP (00000) \_\_\_\_\_

Contact Person \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Telephone No. \_\_\_\_\_

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices**(E)** Supplier's Name \_\_\_\_\_

NSC Identification No. \_\_\_\_\_

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY) \_\_\_\_\_

City \_\_\_\_\_

State (US) \_\_\_\_\_

ZIP (00000) \_\_\_\_\_

Contact Person \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Telephone No. \_\_\_\_\_

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices**(F)** Supplier's Name \_\_\_\_\_

NSC Identification No. \_\_\_\_\_

Address (U.S. POSTAL SERVICE ABBREVIATIONS ONLY) \_\_\_\_\_

City \_\_\_\_\_

State (US) \_\_\_\_\_

ZIP (00000) \_\_\_\_\_

Contact Person \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Telephone No. \_\_\_\_\_

( ) -

Select the product categories the supplier provides to the nursing home for its residents.

☐ Non-Customized Orthotic Devices

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0748. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

## Form H: Monitoring Form

This form is to be used by the local ombudsman to observe and record Demonstration Suppliers' level of quality and service during the demonstration. For any answer, provide explanatory notes where appropriate. Note: The supplier is not required to have each of these items. Instead, this visit is to determine whether the supplier is fulfilling the requirements and standards essential to its demonstration status.

1) Date \_\_\_\_\_ 2) Metropolitan Area San Antonio, Texas

3) Supplier's Name  
*Note if different from the  
name of the location  
visited.*

4) Address of the  
Location Visited

5) NSC No. of the  
Location Visited

6) Name(s) of  
Person(s) Interviewed

7) Title(s) of Person(s)  
Interviewed

8) Is this on-site visit scheduled annually or prompted by a complaint? ☐ Annual ☐ Complaint  
If "Complaint," what is the complaint and how was it resolved?

### General Information

9) Does the supplier have an emergency plan in the event of a natural disaster? ☐ Yes ☐ No  
Examples include prolonged power outages, hurricanes, tornados, floods, etc. If  
"No," explain

10) Has the supplier ever had to execute its emergency plan in the event of a natural disaster? If "Yes," describe when and how. ☐ Yes ☐ No

## Form H: Monitoring Form

11) How would the supplier retrieve equipment in the event of a manufacturer recall? \_\_\_\_\_

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---

### Patient Files

Randomly pick no less than four patient files and check for Items (12) – (19):

- |   |                              |  |
|---|------------------------------|--|
| 12) Physician Order   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 13) Signed delivery/invoice receipt   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 14) Certificate of Medical Necessity (if applicable)                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 15) Documentation of written instruction for beneficiary and/or caregiver   | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 16) Documentation of follow-up, pre and post-delivery                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 17) Documentation that equipment is tracked                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 18) A patient-signed HCFA-1500 claim form or form/letter assigning benefits | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| 19) Evidence of tampering with documentation. If "Yes," describe.           | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
- 
- 
- 

### Computer System

- |  |                                     |                                    |
|--|-------------------------------------|------------------------------------|
| 20) Does the supplier's software differentiate demonstration items from non-demonstration items (to track supplier's demonstration volume)?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| 21) Does the supplier's software differentiate demonstration claims from non-demonstration claims (to track supplier's demonstration revenue)? If "Yes," how does the software distinguish claims? | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
|  | <input type="checkbox"/> HCPCS Code | <input type="checkbox"/> Allowable |

### Demonstration Claims

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 22) Are the supplier's demonstration claims being paid at the correct (demonstration) price? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23) Does the supplier receive timely reimbursement for demonstration claims?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## Form H: Monitoring Form

24) On average, how long does it take Medicare to pay the supplier's demonstration claims? \_\_\_\_\_

25) How does this timeframe compare to that of non-demonstration claims in Question (24)? \_\_\_\_\_

### Purchase/Supply Items

26) Is the supplier a Demonstration Supplier for purchase/supply items? ☐ Yes ☐ No  
If "No," skip to Question (31).

27) How do patients receive their purchase items from the supplier? Check all that apply. ☐ Supplier Delivers ☐ Supplier Mails/Ships  
☐ Patient Picks Up from Retail Location

28) Are the supplier's demonstration patients offered the same brands of products as the supplier's non-demonstration patients? If "No," explain? ☐ Yes ☐ No

29) Does the supplier have difficulty providing specific items within a purchase-only category? If "Yes," which products? ☐ Yes ☐ No

30) Is the supplier providing supplies for demonstration patients renting equipment from another supplier? ☐ Yes ☐ No

### Oxygen Patients

31) Is the supplier a Demonstration Supplier for oxygen? If "No," skip to Question (39). ☐ Yes ☐ No

32) Has the supplier switched demonstration patients from liquid oxygen to concentrators? If "Yes," at whose request and why? ☐ Yes ☐ No  
☐ Doctor ☐ Patient ☐ Supplier

## Form H: Monitoring Form

- 33) Has the supplier reduced the amount of portable oxygen it supplies to demonstration patients? If "Yes," at whose request and why? ☐ Yes ☐ No ☐ Doctor ☐ Patient ☐ Supplier

- 34) How does the supplier monitor its oxygen patients? Check all that apply. If the supplier does not monitor, skip to Question (36). ☐ By Telephone ☐ In Writing ☐ In Person ☐ Does Not Monitor

- 35) How often does the supplier monitor its oxygen patients? \_\_\_\_\_

- 36) What type of employee performs follow-up assessments on oxygen patients for the supplier? Check all that apply. If "Other," explain. ☐ Technician ☐ Clinician ☐ Other

- 37) Does each portable oxygen patient have a backup system separate from his/her actual portable system? If "No," explain. ☐ Yes ☐ No

- 38) How often does the supplier provide maintenance on its oxygen equipment? \_\_\_\_\_

## Form H: Monitoring Form

### Capped Rental Equipment

39) Is the supplier a Demonstration Supplier for capped rental equipment? ☐ Yes ☐ No  
If "No," skip to Question (43).

40) Has the supplier had difficulty determining the accurate rental month for transitioned patients? If "Yes," explain. ☐ Yes ☐ No

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41) Does the supplier have copies of Purchase-Option Letters sent to transitioned patients by their previous suppliers? If "No," explain? ☐ Yes ☐ No

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42) Have any of the supplier's patients chosen to upgrade capped rental equipment included in the demonstration? Describe how the upgrade option worked for the supplier. ☐ Yes ☐ No

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### Patient Transfers

43) Has the supplier transferred patients from other suppliers? If "No," skip to Question (46). If "Yes," from what type of suppliers and for which product categories? ☐ Yes ☐ No  
☐ Demonstration ☐ Non-Demonstration

---

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44) What is the supplier's protocol for transferring CMNs from other suppliers? If "N/A," skip to Question (47). ☐ N/A \_\_\_\_\_

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45) Does the supplier have concerns regarding CMN transfers? If "Yes," what are they? ☐ Yes ☐ No

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## Form H: Monitoring Form

### Subcontracting

46) Is the supplier currently using a subcontractor for any demonstration product categories? If "Yes," who is the subcontractor and for which product categories? ☐ Yes ☐ No

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47) Is the supplier a subcontractor for a Demonstration Supplier? If "Yes," for which supplier and which product categories? ☐ Yes ☐ No

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### The Demonstration

48) How many new demonstration patients has the supplier served since October 1, 1999? \_\_\_\_\_

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49) Do referral sources recommend the supplier's services for demonstration items? ☐ Yes ☐ No

50) Do referral sources recommend the supplier's services for non-demonstration items? If "Yes," how many referral sources do this? ☐ Yes ☐ No

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51) Is the supplier receiving referrals from Non-Demonstration Suppliers? ☐ Yes ☐ No

52) Have demonstration patients or referral sources complained to the supplier about the demonstration? If "Yes," describe. ☐ Yes ☐ No

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53) Is the supplier experiencing any problems related to the demonstration? If "Yes," what are they? ☐ Yes ☐ No

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## Form H: Monitoring Form

### Remarks

54) Supplier's Remarks (If Any)

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55) Ombudsman's Remarks (If Any)

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Interview Completed by

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Date

---

Time

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